Supplementary Table 3. Themes and quotes

Impact of key messages

Patients/Family	Healthcare Leaders
LITTLE/NO INFORMATION PROVIDED <u>Lengthy wait with no answers</u> I waited for a year and a half from January 2020 until July 2021 to have my neurosurgery. The hardest part was getting a referral. The doctor said they referred me but I never heard back from the endocrinologist. And I couldn't get an answer for that, like supposed to be within two weeks you hear the referral went through, and it was at over four months. And I didn't hear. Patient 3 (PT Focus Group 1) What I think everybody has alluded to is communication and missed opportunities and cracks in the system. We forgot. We don't have a better way of knowing what your surgery times are. We don't know what's happening. The surgeon is not in the office right now. I'm sorry I cannot get back to yet because I don't know his or her schedule. Those are very unacceptable comments to share with a patient. Technology exists. The healthcare system hasn't capitalized on those, namely to do with clinical processes and budget. Patient 6 (PT Focus Group 1) I was expected to have my reversal surgery in May or June of 2020, and I never heard anything. And so I received a letter finally from the hospital saying we're doing the procedure in July. So then I heard from my surgeon saying we'll probably do your reversal surgery in November. And then I never heard, never heard, and then finally I received a letter saying I was having it in January so it was just waiting and not knowing and not receiving any information. Patient 4 (PT Focus Group 1) I was supposed to have my surgery the week of the lockdown. I called my surgeon four months after things locked down when things were sort of getting back to starting up again. And the message that I got was, This is so and so's office. Thank you for calling. But if you're calling about your surgery, we don't know what the circumstances are, and we will call you when we're able to put you back on the list or when the list is up. But there was no information as to what else am I supposed to do. So I think that was a bit confusing. I just spoke to the surgeon's office this morning actually and they said, Oh yeah, we sort of forgot call you. And so now I'm back on the list, but I think there was a huge backlog. (Patient 5 (PT Focus Group 1) So a lot of uncertainty, a lot of non-communication from the hospital. Understanding that they are in crisis mode, but there was no possibility of getting in touch with anyone, which	LI**TTLE/NO INFORMATION PROVIDED** <u>Little notice/time to prepare for ramp-up or shut-down</u> One of the things that we've seen, especially in the surgical network, is a lack of communication from government. For instance, when the extra funding and the extended hours for surgery were announced by the government we got one day's notice that we needed to have a meeting with the members of the Ministry of Health. So we at least had some upfront information before it went public, and we really took them to task for that because there was not enough lead time Healthcare Leader 2 (HCL Focus Group 1) One of the most significant challenges is the starting and stopping. There's a lack of appreciation of all of the lead time that is required in order to get things done so the funding methodology is actually creating chaos in all of the operations Healthcare Leader 20 (HCL Focus Group 5) <u>Lack of information to convey to patients</u> We obviously get the edict on how things are going to restart but the informal messaging was, for elective general surgery that isn't high on the priority access target list, you're going to wait. And we can't really tell you when you're going to get those cases done. Nobody ever says that overtly, they just tell you what we're going to do. Up until a few months ago, we were just telling patients you're just going to wait and we can't tell you exactly when we're going to get going again Healthcare Leader 5 (HCL Focus Group 2) <u>No direction or support from health system</u> I know there was $300 million the government has announced. I don't know if all the hospitals got something or not. I hear informally, not a lot. And then there was a $35 million fund that I don't think anyone got. We applied, we haven't heard anything. So is the government really serious about addressing this, and the messaging is no message, really. [Healthcare Leader 8 (HCL Focus Group 2)

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was very anxiety producing, when you're left out in the unknown. Patient 8 (PT Focus Group 2)

I had the feeling that the surgeon's office and his office administrators…weren't sharing information that they should have been sharing with me. Patient 9 (PT Focus Group 2)

As a patient, you're going 'what's going to happen to me'. And then, if you are trying to get information yourself with the hospital, you can't get people on the phone and you don't have emails and there is not much on the website right so it's all these things that myself I would try to go through. Even my family doctor was difficult to get a hold of because she, I only had phone consults with her throughout COVID. She wasn't really equipped to do video conference, she doesn't use apps, you know, she just started doing email. So, she also had to turn around so I felt a little bit like a communications desert, when it came to my own sense of being taken care of. And I'm downtown [city], like I'm not even in the healthcare desert, like there's lots around me, but there was no communication. So the message was crickets really. Patient 8 (PT Focus Group 2)

Inability to plan for life or family

It just helps with planning and everything else with life. Patient 5 (PT Focus Group 1)

The more informed the public is, they can make plans and decisions for their family, you know, just in case something happens. They can plan ahead, like estate planning, all those things Patient 10 (PT Focus Group 2)

Patients are your number one priority in healthcare, but we're also the ones with the lowest amount of institutional knowledge. Knowing a little bit of what is ahead of us or why things are not moving, is helping us manage this anxiety. Having a person that can say in a note or phone call, 'Hey, we know you've been waiting for this, we haven't forgotten you.' Patient 8 (PT Focus Group 1)

Anxiety, depression

The message from the departments that I was getting treatment from was very ambiguous. I also have the services of a nurse practitioner, and when I asked her, she was able to give me a date that was almost precisely accurate. It gave me the impression that the information existed. It was just being withheld from me specifically, and that was really upsetting Patient 7 (PT Focus Group 1)

I had an incident in February 2020 so it was just before the first lockdown of the pandemic. I was seen in Emergency, stayed a couple days and went home and waited until three weeks ago [Fall 2021] to get the procedure. And because this incident caused me to have to abandon a lot of activity that I was doing, it created a lot of anxiety for me and a depressive

The backlog was a very hot topic in the summertime, where there was almost a daily article coming out about how about bad the backlog has been. And then that seems to have quieted down recently. It's a catastrophic problem for patient care, but yet the issue does not seem to be on the public's radar, from my perspective. Even the [provincial planning organization] doesn't seem to be really talking about this with any degree of frequency or consistency. Does agree or not but that's my take on it. Healthcare Leader 10 (HCL Focus Group 3)

Confused by conflicting information

Where it started to get complicated was where we were hearing ramp up, ramp up, but don't ramp up. But you still have to staff ICU, and you don't have staff, but still ramp up and we'll give you money, but there's no staff. So that's where things were getting a little bit confusing to be honest. And then you know the pre-op guidance that would come out was actually very confusing as well. Because at one point it's like, test everybody. The next piece is, well you're spending too much money on testing and screening, so claw it all back. And so it was really up and down, up and down every day trying to ramp up. Healthcare Leader 16 (HCL Focus Group 4)

SITUATION IS BACK TO NORMAL

Still struggling with backlogs and how to prioritize patients

The, the messaging, we're getting recently though is that they're looking at our numbers and saying, oh you know you're pretty close to pre COVID numbers in terms of what you're accomplishing so I think you guys are good. We're totally not good, it's not addressing the backlog at all because it's actually just kind of meeting even Healthcare Leader 6 (HCL Focus Group 2)

And yet if you look at the difference between urgent versus elective our numbers are much, much higher in urgent. So, it's not being addressed head on. Healthcare Leader 6 (HCL Focus Group 2)

Much of it is related to the fact that our human resources are really sparse, so we don't have even close to what we had in a regular year and we're trying to do more. Healthcare Leader 6 (HCL Focus Group 2)

state, because I had to change the way I was going about my life. Patient 8 (PT Focus Group 2)

Concern about disease progression/survival

So, in October of last year I had an emergency hysterectomy for a suspected ovarian cancer. And that turned out to be stage four appendix cancer. So, it had metastasized all over my abdominal organs and, at which point I was immediately They were referred me to [hospital], and once I was seen, the only treatment that was available to me was a very aggressive operation that's only available at [hospital]. Nobody would even talk to me about a date because of the COVID pandemic. So, the way it was explained to us is at any moment our ICU could be full of patients and we can't offer you surgery. All said and done, I didn't end up waiting as long as I had thought. I only ended up waiting about four months. But for someone who's just been diagnosed with stage four cancer, time is of the essence and I just felt like a ticking time bomb. Participant 10 (PT Focus Group 2)

COVID HAS PRIORITY OVER OTHER CONDITIONS

Felt guilty for receiving care despite COVID priority

It was really prioritizing COVID patients, that's what I heard. And I felt bad because I even though the incident was, you know, unexpected for me and it was, you know, not a condition that I had before I, I went to emerg that day, I still knew what I had but if I'd been waiting for a diagnosis or confirmation or treatment after a confirmation of a diagnosis. I think that would have been, you know, even more difficult to kind of live with that, knowing that there was something that could be done. To me it was, it was very much a lifestyle change and waiting to better understand why I had had this incident. And that's why we did the procedure. Patient 8 (PT Focus Group 2)

Confusion about who was getting treatment

I would hear of people who had surgeries, and I was like okay, somebody did have a knee surgery or whatever, so I guess some people are getting in, but it wasn't clear to me how that was all being decided. But the people in the early stage, the diagnostic stage, were the ones that were getting pushed aside Patient 2 (PT Focus Group 1)

I always feel like you hear stories about well so and so got this done before that got done, and was that just luck or somebody being forceful? You kind of wonder about the fairness of it all and the equity of the access Patient 2 (PT Focus Group 1)

Living in living in [urban area], I have access to more stuff than my cousin who lives in [rural area]. That's just something we've been struggling with in the province and anything that we do to improve the system needs to take that into account. and ensure that it's there. Patient 2 (PT Focus Group 1)

Wait2, which is the time to surgery, you only get counted as a Wait2 once you finish the case. So, if you're not doing cases actually, that the numbers don't actually go up all that much in fact they paradoxically go down a little bit and you know even, even now, in general surgery, if you look at the Wait2s for general surgeons, they actually are within the target, and they're within the target because the cases, you know the cases that were waiting a long time, aren't usually the ones that are getting done for some reason I think that falls in the you know the comments that people had before about, you know, 30% of the cases kind of falling, falling off the list Healthcare Leader 5 (HCL Focus Group 2)

CONCERN FOR STAFF WELL-BEING

Healthcare staff are getting no relief

A lot of mixed messages come from different leadership, either local senior leadership teams and or government. Things like, everybody take care of themselves, try and get time off, yet the expectation is that you never have time off, and that you're always at the end of your phone and managing. Healthcare Leader 20 (HCL Focus Group 5)

SINGLE OR UNIFIED APPROACH

Each hospital or region has unique needs

It feels like we're trying to act as a singular entity, yet the infrastructure doesn't exist to support that. We all have local collective agreements, local nuances to all of our staffing, local nuances to the type of work we do and don't do, because some of us are specialty hospitals and others are community teaching hospitals like mine. But the mixed messages continue. Healthcare Leader 20 (HCL Focus Group 5)

The Chief Medical Officer of health makes a directive so that is a legal directive and everything has to shut down. Okay. But he makes that at a provincial level, and then that has to be then carried out by a myriad of healthcare organizations, whether it's community hospitals, teaching hospitals. And that's where I think that the message gets reinterpreted or interpreted differently in one hospital to another. Multiple levels of cascade that come down to a practical implementation of whatever the directive is Healthcare Leader 4 (HCL Focus Group 2)

Frustrated with being considered unimportant

The key message or the key takeaway I took was that COVID was the priority. I felt like it didn't matter that I was dying of cancer. I felt like I would only matter if I had COVID. Clearly not what anybody would say. But all these beds were being reserved for COVID patients in my case. Not even necessarily being used, they were sort of set aside for a potential case, when I'm sitting there with a definite need for it, and still being placed on the sidelines to wait. Patient 10 (PT Focus Group 2)

So it wasn't until I, when I approached my doctor on two occasions for two different instances and his was always, you know, starting with the lowest common denominator of physio and that kind of thing so surgery, even though I felt. The surgery was the option that was I wasn't encouraged to go that route. Patient 1 (PT Focus Group 1)

To me, it was all very confusing. The message I was getting is, don't even bother, there nothing, nobody's available. We're putting 100% of resources into COVID patients, and that if you have an issue, try and deal with it your best way you can. Patient 1 (PT Focus Group 1)

NOT SAFE TO GO TO HOSPITAL

Concern about risk of untreated condition versus contracting COVID

What I wanted to say is that they basically make you feel as if, with your condition, you're actually safer not going into hospital and getting surgery, because there's a higher risk of contracting COVID. Patient 11 (PT Focus Group 2)

They make you feel like your condition is not important or valuable. What you're going through is life-threatening. There's a chance you could contract COVID, but there's 100% chance you could have a fatal condition that needs immediate attention. So I think they shouldn't be patronizing, but they should be like 'okay, we're going to work with you to get you your treatment as soon as possible and not delay things.' Patient 11 (PT Focus Group 2)

Patients avoid seeking care or turn to private sector

It may it may make people hesitate to go in. It may make people feel like it's not worth it, or the other drawback is they're going to do like healthcare tourism if they can afford it. They're gonna try and go get care in the US, or in the Caribbean or whatever, right. Like, it's making a good case unfortunately for the private sector for those who can afford it. Patient 8 (PT Focus Group 2)

I have a lot of medical issues so it's like, thank God, I don't have something major going on, so try to avoid the hospitals at all costs Patient 2 (PT Focus Group 1)

LACK OF OR TIME

Oncology procedures are prioritized over others

Well there's been lots of meetings with our hospital administrators, the hospital leads to try and advocate for long waiters and they keep saying 'yes we're working hard, there's just not enough OR time for any of us, everyone's fighting for a piece of the pie,' but when we looked at the stats, the oncology patients are actually getting in on time so it seems like there's a disconnect between what's being said and what's actually happening. So at the level of non-oncology cases, we're really working hard to try and advocate for that, but it's been challenging. Healthcare Leader 11 (HCL Focus Group 3)

My practice is almost exclusively oncology, and if it's a non-oncology label, all of a sudden it's a non-entity in terms of a priority. This is very anecdotal, but I had overheard a hallway conversation about a patient with chronic orthopedic pain and significant mental health who was waiting surgery and actually committed suicide on the waitlist because of his chronic pain. Healthcare Leader 12 (HCL Focus Group 3)

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SURGERY COULD BE CANCELLED AT ANY TIME <u>Anxiety about being bumped and forgotten</u> Yeah, absolutely. And I was also a message I received was prepared to have your surgery canceled right up until the last second. So even when I had been given a date. It was very precarious in my mind, because I could be bumped at any moment. Patient 10 (PT Focus Group 2) Yeah, true that happened to me as well. I got bumped twice and then forgotten. if I hadn't called in September, I would not have gotten my procedure in October Patient 8 (PT Focus Group 2)	
SOURCE <u>Multiple sources, but all insufficient</u> Information from the media was very minimal. From the government, surgeries are on, surgeries are off, elective-wise, it was helpful but very simplistic in terms of the message. From medical professionals from the hospital and from the departments that I was getting treatment from, it was very ambiguous. I was given a very vague timeline going forward in terms of when my surgery was going to be happening. So more information. Patient 7 (PT Focus Group 1)	**SOURCE** <u>Top-down cascade</u> We have a lot of messaging regularly from government authorities and it trickles down through the hospital authority so it seems to be coming very much top down. Healthcare Leader 11 (HCL Focus Group 3) We were getting our messages from the [government] table, and because we had this meeting every day, our Chief of Surgery would start with those announcements. Healthcare Leader 15 (HCL Focus Group 4) <u>Informal channels from colleagues</u> Mostly from my colleagues that are working in different areas across the province. [Healthcare Leader 2 (HCL Focus Group 1) We all checked with each other, there was a lot of people reaching out to people, it was this constant little vortex of hospitals calling hospitals. Government was silent in wave one. Messages were

	coming from our own network of talking to each other. Healthcare Leader 14 (HCL Focus Group 4)

Recommendations for communication about wait times

Patients/Family	Healthcare Leaders
CONTENT <u>Educate patients and the public – explain why there is a backlog</u> Even though time estimates may not be possible, just giving any qualitative information explaining what's going on, what the bottlenecks are, what's being attempted, what's making things more difficult. Definitely makes you more sympathetic, understanding, and happier with the situation. Patient 7 (PT Focus Group 1) Even if the absolute time can't be improved past a certain point, it can certainly feel like there's been less delays if things have been communicated better. Patient 7 (PT Focus Group 1) An understanding, just in general, of how surgeries are being booked. And why there's this backlog and things were being moved into what should have been my spot. Not having that information, really gave me the sense that my case was not important, even though all the medical information that I had said it was urgent. Patient 10 (PT Focus Group 2) Managing expectations. Information can improve performance from a patient's perspective, even if the absolute time can't be improved past a certain point, it can certainly feel like there's been less delays if things have been communicated better. Patient 7 (PT Focus Group 1) <u>Regular updates of position on wait list</u> Is it possible to see where your name falls on a waitlist? Without giving away other people's personal information. 'You are number 126 on a list of 341 hip replacements for 2021' and you can see your name, move up or down the list on a weekly or daily basis and you can track it so you can sort of have some sense of when it's going to happen. Patient 10 (PT Focus Group 2) **MECHANISM** <u>Digital (email, phone app, web site, patient portal): refer to later, openly available</u> I'm an email person. I would like to have had something that I could look back on to refresh my mind about why things were happening Patient 10 (PT Focus Group 2)	**CONTENT** <u>Educate the public – publish wait times and explain why there is a backlog</u> From a public point of view, transparency is an excellent point. The government needs to set a realistic expectation for the physicians because right now this is getting put on us. We're the people that are face-to-face with the patients and we're going to be the ones that have to explain this, but we're not feeling backed up by the government because they're smoke and mirrors, everything's fine. And it's not. Healthcare Leader 13 (HCL Focus Group 3) The community and the general public don't understand what's included or what's not included in an acute care and what's paid for and what's covered and what's not. So there needs to be broad sweeping consistent messaging. Healthcare Leader 20 (HCL Focus Group 5) [note: in reference to comments about patients/families arguing against discharge] The public needs more education, because it's all about 'oh, we're back to normal, let's go.' The government, I wish that they would be more realistic, because the people coming in are not realistic in their expectations for the wait times. Healthcare Leader 18 (HCL Focus Group 5) I'm not sure that the public truly understand the wait, what impact [COVID] has had. There's not enough data out there to fully articulate what the outcomes for our patients have been over the past 18 months and delaying their surgery, etc. Healthcare Leader 19 (HCL Focus Group 5) What we need from the Ministry is clear communication and that this is a very complex issue and is going to take somewhere between two and four years to even reasonably address what the backlog currently is, let alone what the waitlist was prior to the pandemic that many of us were struggling with. Healthcare Leader 19 (HCL Focus Group 5) I think the government needs to say this is a page of all the wait times in the province. They need, people need to understand the wait times on every area. [Some procedures] are getting more attention because it's money making and everybody gets slashed and burned. Hernias are waiting up to almost a year and a half. And so the public doesn't understand all this. Healthcare Leader 18 (HCL Focus Group 5)]

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I'm very digital first, so if it was an email that would help me, or if it was through an app on my phone from the Ministry, like, I'm fine with that but I know it's not everybody so it could also be on the website, saying 'At [hospital] our current delays for knee surgery are six months or 18 months,', Put it out there because everybody has it. They were all putting their cases of COVID on the website so why not put the wait times up there too. Patient 9 (PT Focus Group 2)

Having an electronic patient record I can access and where I can see updates on my wait times would also be helpful Patient 8 (PT Focus Group 2)

Any means of communication is useful

It doesn't really matter. As a young person who's pretty tech savvy, I don't really care. I just need the information, whether it's through a portal, or my family doctor, or the surgeon's office or through the Ministry. Patient 5 (PT Focus Group 1)

It could be on the list or it could be communicated to you by your doctor, it doesn't matter. I think it can be private or public. But as long as the patient knows it. That's the communication that's lacking all the time. Patient 8 (PT Focus Group 2)

Two-way communication/opportunity to ask questions

Where the there's an opportunity for the patient or the caregiver to ask follow up questions. So instead of having one-way communication, there needs to be some form of having two-way communication, to say 'okay, I don't have access to those questions, but maybe I can have the surgeon or someone call you with those answers.' Patient 6 (PT Focus Group 1)

The people who are in charge of booking procedures are not necessarily empowered to take the time to explain things to you. They go through things very quickly. When you're stressed or anxious, it's hard to retain the information, and English is not my first language. Even if I'm a high-functioning person, and they want to be very efficient and book, book, book it's like, I need you to tell me all this, and then send it to me an email so I can review. And if I have questions, I can go and ask you or someone. Give me a resource that I can talk to. Because everything I was told was rapid fire 'you need to do this, you need to do that,' I was confused. And then they sent me a requisition and I didn't know what to do with them. So it was very difficult for me to have all of that thrown at me all at once, and no invitation to ask any questions. Patient 8 (PT Focus Group 2)

DISAGREEMENT: cause fear, overload emergency services

It's going to cause fear and we're going to end up seeing patients coming through to emerg to try to get in, there is a risk for that. Our emerg is already backlogged and cases are coming in. I think there will be panic and fear. Healthcare Leader 17 (HCL Focus Group 5)

It's so extremely complicated to explain in a very generic public way. I'm not sure how effective that would be. I think the focus should really be on what are the root causes, so that it's clear that it's around staffing and funding. Those are the problems. Healthcare Leader 20 (HCL Focus Group 5)

Communicate degree of uncertainty to mitigate expectations

More messaging around the fact that there is going to be a massive amount of uncertainty around this. And just because you have a snapshot of data that you think really represents the reality on the ground, when we know that there are many reasons why that data doesn't actually reflect what our day-to-day reality is. It may be easier said than done. Healthcare Leader 13 (HCL Focus Group 3)

DISAGREEMENT: Feasibility not likely

Messaging to the public about expecting uncertainty in your healthcare is probably accurate. Although I must say I just don't see government actually doing that because they're all about certainty and providing the assurance, and the government would never come out and say 'Sorry folks, we don't know what's going to happen. We'll do the best we can,' although that's probably the reality. Healthcare Leader 10 (HCL Focus Group 3)

Refrain from using the word 'elective'; shift focus to degree of suffering

If I could have any wish in the world right now it's to remove the word 'elective' from everyone's lexicon and change it to a word that has a better impact on the public. Healthcare Leader 10 (HCL Focus Group 3)

I echo the conversation around the word 'elective'. In the public's eye, they don't perceive that word in the way we perceive that word. I feel physicians right now or are not anyone's favorites and we're getting gas-lighted a little bit, and I think the terminology and the communication out there is what's causing that. Healthcare Leader 13 (HCL Focus Group 3)

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Regarding communicating and not being able to retain everything, that was something that was especially difficult during COVID, because we weren't allowed to bring significant others to appointments. And we were receiving huge amounts of very scary information. And you're trying to put your emotional reaction aside so you can hear what the doctor is trying to tell you that you need to do. And nobody really accounts for any of that. I remember coming out of the ICU and I'm getting all these instructions and I don't know what they said an hour later. Patient 10 (PT Focus Group 2) It's important for the assistants to communicate better because the doctors often don't have the time, but an assistant could at least answer the phone, you always have to leave a message and no one calls you back and you leave another message and it said to only leave one message. And I found it very, very frustrating. So the people who support the doctors, their assistants, maybe they need more of them if it's too much work for them. But I think they just have to do a better job. Patient 3 (PT Focus Group 1) <u>Ensure equitable access to information among vulnerable or hard-to-reach groups that may lack technology (e.g. cell phones, Internet)</u> I think you need to find some equity in terms of how some of this information will be shared. One of the things to think about is how to reach patients of color, Indigenous people, those who have don't have access to, electronics, or cell phones or emails. I think that should be said, definitely be at the forefront, as we think about communication strategies. Patient 6 (PT Focus Group 1) **SOURCE** <u>Single group dedicated to communication</u> Have a single body that communicates to all patients that are in the system that talks about here's our priorities, here's our policies for how we make decisions. Patient 2 (PT Focus Group 1) Have a dedicated group to take care of communication of all kinds. I don't have the sense there is a communications group. If there were, and their job was a hundred percent to try to provide the kinds of information people were needing, that's what they do. I don't know if that exists. I don't think it exists at the hospital level. And so I'm not sure about the government. Patient 9 (PT Focus Group 2)	The word 'elective' has such a misguided connotation for the public. You know there are other better words like scheduled operations that might make more sense. 'Elective' sounds like it's expendable. When I hear about elective surgeries being delayed it always gets my back up because nothing about this is elective. Healthcare Leader 10 (HCL Focus Group 3) Communication was underplayed, because they kept calling it elective surgeries and that suggests things like facelifts and wart removal. We have people waiting for hysterectomies because of low grade cancer, we had disabled people in wheelchairs who couldn't get arthroplasty surgery, we had people with coronary vascular disease who were 72% left main occluded with chest pains, they had to wait. We had aortic valve surgery put on hold. [Healthcare Leader 14 (HCL Focus Group 4) We all had to come up with our own definitions of urgent or semi urgent. Healthcare Leader 14 (HCL Focus Group 4) Oncology cancers, for example, my world of thyroid cancer, although it is a cancer, it is by no means a serious cancer, it can wait months and months and months without any risk to the patient. The way this has been perceived and told to the public has a long way to go in terms of appropriate communication about severity of even non-oncological problems. Healthcare Leader 10 (HCL Focus Group 3) Cancer always evokes a certain response of fear and rapidity in the public and so it should because of course oncology, in many cases is a highly critical, but the concepts of extreme suffering being experienced by those who have non-oncological problems but still critically important issues that require an operation is not at all being stressed. There's a sense that cancer must prioritize over everything. I'm not here to debate what's the more important specialty or treatment, that's not the point. The point is that it isn't reasonable to just have the government or funding agencies focusing specifically on oncology cases, when there is so much suffering out there from non-oncological [conditions] and so messaging must be about not just cancer therapy but alleviating suffering. Understanding the effects of a backlog on somebody's wellbeing, on society's functioning, on health economic outcomes. It's not just about oncology, and it's not about, as I said earlier, elective work. It's about those who are suffering, who need the operating room to alleviate their suffering. And there are better ways to convey that message of empathy. Healthcare Leader 10 (HCL Focus Group 3)

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Having dedicated communication units solely devoted to communicating with patients and they're experts in that, they have the time to do it, it's their job. Patient 9 (PT Focus Group 2)	**MECHANISM** <u>Engage surgeons in system-level decision-making</u> [The government] hey had zero input from anyone in the surgical community when they made their decisions. Healthcare Leader 2 (HCL Focus Group 1) I think it's important that government keep the key stakeholders informed of what's going to be happening or and seek some advice from people in the surgical communities, because I find that some of the provincial tables are a little distanced from actual practice. Healthcare Leader 2 (HCL Focus Group 1) We've had a couple of meetings with government where they send you an email 'there's $700 million going towards this' and you sign up for the meeting and then you're three slides in and the funding is gone, and it's more of a 'let's see how you do it and report back to us.' So I think in those two examples from our hospital were very frustrating. I think the expectation being surgeons are going to do it longer and work harder to fix this. And there was no conversation back to us about how we felt about that and asking that of us. So I think as a surgeon, that's one of the things that I find stressful. Healthcare Leader 13 (HCL Focus Group 3) As a surgeon, I would like someone to ask my opinion as to what can I do, and what am I available to do Healthcare Leader 13 (HCL Focus Group 3) Why can't we get a letter [from the Ministry of Health] actually saying 'it is our understanding that the surgical backlog is this and that your organizational surgical backlog is reflected in our data as such, please validate,' that would have given us an opportunity to actually correct. Healthcare Leader 14 (HCL Focus Group 4) There really wasn't any surgical representation at any of the provincial committees. There was emergency room representation, there was critical care representation. But to date, there hasn't really been a grassroots level surgical recovery group. When the numbers came out from the Ministry with regards to backlog, it pressurized institutions to actually start moving in a direction without resources. And compounding all of that is that the numbers they were using were previous surgical numbers. So they were actually number of procedures completed the year prior. So you need some focus on surgical recovery and you need the right players at the table helping shape and make some of those decisions, because what's happening right now is we're getting instructions and

	direction, but it's not aligned with what we're able to do and what the grassroots level priorities are. Healthcare Leader 16 (HCL Focus Group 4) Maybe a core working group with some of surgical directors, some of the chiefs-of-surgery, because I know some of these meetings are happening separately. It might it might be a good time to pull everybody together with the Ministry at the table to start having those grassroots-level discussions so that we can actually move forward. Healthcare Leader 16 (HCL Focus Group 4) <u>Prompt patients to advocate to government</u> The patient voice is so important. That's the only thing that moves the needle in the government side. When patients are calling our office and complaining, rightly so, that they are in so much pain and disabled and still waiting for surgery, we actually give them the patient care quality office number at the hospital, and it does get attention. That's one of the mechanisms to move the needle a bit Healthcare Leader 11 (HCL Focus Group 3)

Recommendations for managing wait times

Patients/Family	Healthcare Leaders
PREVENT ILLNESS <u>Funding for health promotion</u> Can we get more funding for physical activity in the general public so that people have access to gyms and training programs or whatever, and for health experts outside of the system who are not covered by OHIP like massage therapists, physiotherapists, kinesiologists so that it doesn't cost as much to individuals Patient 8 (PT Focus Group 2) Prevention, obviously. I don't know what it is, maybe 98% of funding goes to helping people who have [health] problems and zero might go to preventative medicine. I think that says a no brainer in terms of decreasing surgical demand. Prevention needs to be more of a priority for sure. Patient 9 (PT Focus Group 2) The prevention idea goes beyond just diagnostic procedures, even into the schools. Perhaps this is already the case that our elementary and secondary schools are teaching lifestyle wisdom. Patient 9 (PT Focus Group 2) <u>Workplace safety measures</u> Could we incentivize employers who have dangerous workplaces to have more safety measures so that workers don't fall as much they, they're more strapped in to whatever they're doing. Patient 8 (PT Focus Group 2) **SHIFT SERVICES OUT OF HOSPITAL** <u>Provide support to patients while waiting</u> If there's some arrangement that can be made that would satisfy them. And it wouldn't be dangerous. Such as providing payment for physiotherapy or transportation or homecare or all these things to say, you know, if we can delay you two months, we could provide some support for you. Because I think when people think there's just a delay, it's the cost is on them. And if you took the cost off the patient and supported them. While this delay occurs. Maybe there's a way to reshuffle the demand and spread it out. Patient 2 (PT Focus Group 1)	**PREVENT ILLNESS** The pandemic brought us back 10 years with all of the prevention campaigns that we had with regards to colonoscopy, colposcopy, a lot of those pieces. And I know individually hospitals are trying their best like we're going to religious work, like religious groups etc, but not a lot of people are meeting in person. There's no access to the population anymore. So it's almost like the, if the Ministry, government, whoever, somebody could help us get this word out and start to do some of that advertising on media, social media on TV. That sort of stuff would definitely help because prevention is going to definitely be the key to managing and predicting what our volumes are going to be like. Healthcare Leader 16 (HCL Focus Group 4) **SHIFT SERVICES OUT OF HOSPITAL** <u>Provide support at home after early discharge</u> Same day discharge is a good strategy but I don't know how much they can increase without risking standard of care of the patient. So, that needs to be well thought out for sure. If possible, would be a good idea. Healthcare Leader 1 (HCL Focus Group 1) About the same day discharge. Through the pandemic in the later phases, when we were able to do more of our day surgery joint cases, we were able to optimize that by having remote care monitoring. We have a virtual ward of nurses that call and follow up. So there's a possibility there's other pathways of patients that we could theoretically move through the hospital experience faster if we have the proper supports, which would require community support, but also this remote care monitoring piece as well. Healthcare Leader 15 (HCL Focus Group 4) And I think the other pieces and I alluded to it was converting the same day admits to one day cares, which we have done a significant amount of work in in our arthroplasty and joints, but there are other cases that have now moved to one day cares to try and keep people out of the hospital. Healthcare Leader 19 (HCL Focus Group 5) <u>Move COVID screening to primary care/community</u> Primary care needs to open back up fully. That may decrease the urgency of surgery or recidivism to the ER but it'll decrease the demand for surgery. Because if you do a pap smear, you find a cancer, it may actually temporarily increase it, but it gives an earlier opportunity to intervene, which then potentially gives us more of a timeline without the urgency, that post pandemic phenomenon of people just busting down doors. Healthcare Leader 14 (HCL Focus Group 4)

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Is there potentially an opportunity to incentivize patients to voluntarily accept delays? Obviously there's patient priorities in terms of is it life threatening or is it going to lead to long-term disability if it's not treated well or is it going to inconvenience for a period of time. Perhaps there's a way for some patients that can to self-select themselves for delay, and to incentivize them somehow. I'm not 100% sure of the best way to incentivize or what resources might be available, but that might be a way to self-organize the list. Patient 7 (PT Focus Group 1)] There might be an opportunity for patients to help patients. And I guess what I mean by this is any sort of support groups or having people be able to opt in to connecting with each other. Patient 7 (PT Focus Group 1) I wondered if there were ways to support people. Social work support, psychological support for people while they're waiting. Because the anxiety of waiting is horrible. And maybe that can be a possible way to help. Patient 2 (PT Focus Group 1) <u>Provide treatment in community or at home</u> Provide more in-home services to people with mobility issues or elderly people or for those more minor surgeries. Can we not just go and perform that in the person's house, do we need the whole big OR? If we're going to have NP equivalents do smaller surgeries, if you cut yourself and it's bleeding, can we not send someone to do it at your house, rather than bringing you to emerg and taking a bed? Can we go to them and have more mobile units that can take care of people on the spot. Patient 8 (PT Focus Group 2) I had a uterine biopsy that was delayed twice because of COVID and had to be done in an entire OR room. And I thought this is ridiculous, this little biopsy, this could be done in your office. So my diagnosis was delayed several months just waiting for that biopsy. Patient 10 (PT Focus Group 2) Looking at what needs to be done on site versus what can be done in the community. And trying to think outside of the building and finding those solutions so that we're not always relying on the hospitals for that kind of care. Patient 8 (PT Focus Group 2)	One of the biggest problem in our system is access to care. The GPs have not fully reopened their offices and that's a system problem Healthcare Leader 18 (HCL Focus Group 5) Why do we always have all these COVID assessment centres rather than the pharmacy. They should convert that to more clinics, getting people seen in a timely fashion and not having emergencies. Healthcare Leader 18 (HCL Focus Group 5) I had the COVID assessment centre under me and I just transitioned it to an external provider so we could recapture our staff. Healthcare Leader 20 (HCL Focus Group 5) <u>Provide treatment in ambulatory/community settings</u> The model would also work okay with outpatient gyne surgeries, things like hysteroscopies in particular, because they're already outpatient procedures. There's well defined information available to the patients as far as pre-op and post-op. And I think that would be looked on favorably by the gynecologic surgeons. Healthcare Leader 2 (HCL Focus Group 1) Another interesting point to highlight is maybe the solution around this pandemic is also a bit of an opportunity for us to reflect on what we do that does not need to be done, and this concept of de-escalation, as we have to make some tough, tough decisions moving forward. Healthcare Leader 12 (HCL Focus Group 3) Expand on the use of ambulatory care centers. But it is a different model and it takes a whole system transformation and cultural transformation with physicians, which is not easy. There has to be a lot of buy-in to be able to be successful in transitioning that work. Healthcare Leader 19 (HCL Focus Group 5) There are surgeries that absolutely need to be done in acute centres, one hundred percent, and there are other procedures that don't. The alternate health facility model allows for those procedures that don't need to be done in hospitals and take up valuable OR capacity, and have them done in the community, things like colonoscopies and cataracts. There's a myth that elective surgeries and ambulatory-type surgeries cannot be done safely in the community, and that's a falsehood, and there is existing OR capacity in the community that is not taken advantage of. Healthcare Leader 8 (HCL Focus Group 2) I agree that there's unused capacity in the out-of-hospital premises, but we don't because of the way it's set up. There's not an ability to fund. The previous government had planned to introduce legislation to pull it all under an umbrella framework so we'd have the independent health facilities, out-of-hospital premises, the public hospitals, all under this so that we could fund cases there. That was never implemented, so we're left with a situation where we can't fund the cases. Healthcare Leader 4 (HCL Focus Group 2)

Leveraging more community-based resources may help. Especially if we're looking at ageing populations that may be more at risk of falls or things like that that. having access to care closer to their homes rather than having to go to hospital. Patient 8 (PT Focus Group 2)

Provide home services after early discharge

If you're looking at a surgical procedure that normally would keep someone after the procedure for two days, what are the resources in that person's area that can help them feel safe to go home after one day, and they have the phone number, name and email of the care provider that is going to check in on them. Patient 8 (PT Focus Group 2)

I would try the same day discharge and it's a matter of leveraging additional resources outside of the hospital. Patient 8 (PT Focus Group 2)

Use private hospitals

Use public-private partnerships or private hospitals, coverage to expand capacity. We need different models to perform different types of surgeries Patient 2 (PT Focus Group 1)

DEVELOP THERAPIES TO REPLACE SURGERY

Maybe a move towards therapeutics like medications versus having to go under the knife. if you can treat, let's say a cancer, with a new medication in pill form, liquid form. Patient 11 (PT Focus Group 2)

> DISAGREEMENT: may only delay surgery
> Will that mean that the, the surgical is still needed but at a later date? Maybe it's just delaying the problem instead of dealing with it. If you tried something non-surgical and it's not as effective, is this good for you or for your health? Patient 8 (PT Focus Group 2)

INCREASE POOL OF HEALTHCARE PROFESSIONALS

Incentivize people to enter health professions

We actually reviewed all of our activity in our operating room by the weight that's allocated to each case. We took the smaller-weighted cases and moved them out to the clinic setting, like carpal tunnels, like hysteroscopy. We've saved five operating room days doing that. Healthcare Leader 16 (HCL Focus Group 4)

If I could get funding for a minor procedure clinic with anesthesia mild sedation support, nursing, a little recovery area, then I could take about 10% of the procedures out of the OR that just have nowhere else to go. So they end up coming to the OR. Healthcare Leader 14 (HCL Focus Group 4)

Doing a lot of work outside of the hospital is a very good idea, it could help things almost immediately. Not everything has to be in a major hospital to be done. Healthcare Leader 10 (HCL Focus Group 3)

Use private services

I think the idea of private surgical centers, is an interesting one. It comes down to efficiency in a way, you know, get rid of the unions, incentivize the nurses to get more cases. Efficiency is very variable depending on the hospital and depending on the [procedures] you're doing. If you have focused factories like the [private surgical centre] that are focusing on one thing, they can generally do it well. Healthcare Leader 3 (HCL Focus Group 1)

That's a really good example. In endoscopy, in our hospital, we book 15 cases a day for colonoscopy, and in the private clinics, they book 20. Healthcare Leader 3 (HCL Focus Group 1)

There's already lots of private facilities that are probably being underutilized with staffing and rooms, etc. And we have done that in our province before, where we've used private facilities, but they're funded by the government to do certain cases. Healthcare Leader 11 (HCL Focus Group 3)

We are looking at outside places that might do day surgeries. The little day surgery could be done there. It's not just about money, it's about the space. Healthcare Leader 18 (HCL Focus Group 5)

SEND PATIENTS ELSEWHERE

Send patients out of country

Funding them to go out of country Healthcare Leader 11 (HCL Focus Group 3)

Are there ways to provide incentives for more people to go into nursing and become surgeons and any other health care? Incentives to universities and colleges that provide programs for that. Patient 4 (PT Focus Group 1) There's a shortage right now in the market so I'm not sure if there is a way to maybe fund education for the health sciences to get more of these people into the funnel. Patient 8 (PT Focus Group 2) Getting more people trained to become doctors and surgeons. We're fixing a problem for the long term, as opposed to these small solutions. Patient 10 (Focus Group 2) <u>Redistribute Canadian healthcare professionals</u> I think it's worth distinguishing between long term solutions and temporary solutions. And while it seems we're naturally focused towards ongoing long-term solutions, we should be considering temporary solutions as well. COVID is not gonna last forever, hopefully, and ideas like reallocating doctors, redistributing within the country and from other countries, sort of importing resources on temporary basis. Might be viable, if it's flagged right from the start as being temporary. We have an immediate demand and the need is now. So, maybe just recognizing that there are some temporary short term solutions. That could be very helpful getting us through this next crunch. Patient 7 (PT Focus Group 1) <u>Modify professional scope of practice</u> I see a podiatrist and he told me that he is qualified to do foot surgery but the government doesn't recognize it and forces people with certain foot issues to go to orthopedic surgeons. He said, 'if we were recognized for the skills we actually are trained for to do surgery we could take a big load of the orthopedic surgery that needs to be done.' So I wonder if there's ways of looking at some of the lower risk surgeries and pushing them out of the hospital system. Patient 2 (PT Focus Group 1) When they closed down originally where everything stopped, only [doctors] who are connected to the hospital were working in COVID, but the rest of the clinics, the doctors were not used, not assigned to do anything. They closed down fertility clinics. And the dentists, once they were closed down, they were just sitting at home. I thought it	**MANAGE THE WAIT LIST** <u>Re-assess how procedures are prioritized and funded</u> The government needs to get off this focus of only having hips, knees and cataracts done. Most facilities that are able to maximize that are doing that. They have to look at other surgeries, general surgeries, gynecology surgeries, you know, a lot of these things, only the emergencies are being done, which essentially is driving people through the emergency department and they're not being investigated by the hospital when they could have been. Healthcare Leader 2 (HCL Focus Group 1) If it's a non-oncology label, it's a non-entity in terms of a priority. This is very anecdotal, but I overheard a hallway conversation about a patient with chronic orthopedic pain and significant mental health who was waiting surgery who actually committed suicide on the waitlist because of his chronic pain. Healthcare Leader 12 (HCL Focus Group 3) In my world of thyroid cancer, although it is a cancer, it is by no means a serious cancer, it can wait months and months and months without any risk to the patient. Healthcare Leader 10 (HCL Focus Group 3) There's a sense that cancer must prioritize over everything. It isn't reasonable to have the government or funding agencies focusing specifically on oncology cases when there is so much suffering out there from non-oncological [conditions] Healthcare Leader 10 (HCL Focus Group 3) And the other issue that we see is that the government is for the last at least 10 years has grasped onto knees, hips and cataracts as the only surgeries that need to be prioritized, and all of us recognize that those are not the only surgeries that are performed in [province]. Healthcare Leader 2 (HCL Focus Group 1) I do agree with increased hospital budgets, perhaps even incentivized quality based procedure volume, like last year they did 20% incentive on everything we've done over 50% of your targeted volumes. But I actually think they need to continue those two things, and, and also fund structured plans for each individual organization's surgical recovery. Healthcare Leader 14 (HCL Focus Group 4) Don't tell us six months prior to that you're going to incentivize quality-based procedures (QBPs) and then tell us six months later in a webinar that you're not going to allow us to net QBPs. For example, tonsillectomies have really gone down. And we would typically net the dollars from there to try and do more hips and knees to try to offset the volume, to serve a different population and try to address that backlog. But the word that we're hearing is that we're not allowed to do that anymore. They should identify maybe two or three years as

was a very poor decision the way the government set it up. Patient 3 (PT Focus Group 1) Incentivizing people that wanted to upscale or to add different skill sets or to train up to being able to do something else, to boost your career forward. Taking people that are within striking distance of being qualified and ready to do something, and helping bridge the gap and get them ready so they can. Patient 7 (PT Focus Group 1) If a nurse, for example, wants to be an ICU nurse, it's not easy to do that. You need support, you need money, you need time to go through those education course. If you want to address the shortage of staffing, it's allowing the nurses and physicians to be trained in a timely manner and not making some ridiculous reasons that 'sorry you worked only 5000 hours, we needed 9000 hours for you to work as a nurse.' Patient 6 (PT Focus Group 1) This is kind of wild but, we have different levels of nurses, three-year trained nurse, registered nurses, and then we have practical nurses who can prescribe medications. Could we have a new role related to surgery where we don't have to have full-fledged surgeons, taking on a role between a doctor and a nurse practitioner. Like surgical-trained nurses that can do smaller procedures, just like the nurse practitioners can prescribe Patient 9 (PT Focus Group 2) Train up staff that may not be as in demand as others for one reason or another, and have them redeployed into areas where they can cut through the backlog and other procedures. Patient 7 (PT Focus Group 1) Maybe you've got somebody who's got an ingrown toe nail, not to minimize the seriousness of that for people have had it, but maybe you don't need a specialized surgeon to deal with certain surgeries that are maybe simpler to do. Patient 9 (PT Focus Group 2) <u>Expedite licensing foreign-trained clinicians</u> There are quite a number of international physicians who are trained so I think that may be an untapped. Patient 5 (PT Focus Group 1)	surgical recovery for the backlog and incentivize and fund at all hospitals that can do volumes as opposed to threatening with claw-backs. If the QBPs are not allowed to net, that puts us two steps backwards based on the funding strategy. Healthcare Leader 16 (HCL Focus Group 4) As difficult as this would be as a conversation, is to really start talking to the public as an adult and saying what is actually medically necessary to do and should be funded. And what are some things that unfortunately nowadays we just can't be doing this for everybody under health insurance. And so we're just not going to be using OR time for things that are just not medically necessary to do anymore. Healthcare Leader 10 (HCL Focus Group 3) <u>Verify who is really on the wait list</u> We've actually embarked on a process to verify the actual number of patients on the waitlist. I think it was done in [province]and they found that when you made systematic phone calls to everyone who's on your waitlist. It turns out that up to 30% of them actually are not waiting for surgery anymore. Some don't need surgery, they've sought other means to fix their problem, some have died, some have moved other jurisdictions etc., etc. We're more than halfway through that systematic process and it turns out we may have somewhere between 30 to 40% of names on our waitlist who are listed as backlogged patients who actually are no longer in that pipeline so I think understanding the accuracy of this, this is a challenge and it's really important. Healthcare Leader 9 (HCL Focus Group 2) So, one is to really quantify backlog. How do you know something is on backlog? We have some information in [province][province], things like waitlists and stuff, wait times. But that doesn't really reflect the true backlog as you heard just now. There's people who have not really gone to primary care. So there's an element there that we're missing. Healthcare Leader 7 (HCL Focus Group 2) So we have these priority access targets in general surgery for non-cancer, there's this wait time 4, something you have to get done within 180 days, but I think that if you ask surgeons, there are a lot of people on that wait time 4 list who are minimally symptomatic, it doesn't impact on their well-being or their work, and they probably don't need to be on the list so I think that is something we need to look at again. Healthcare Leader 5 (HCL Focus Group 2) <u>Analyze wait time data accurately</u> Understanding the data and understanding what the true numbers are with the true wait time for each category of patient. And that's when we really had some power and some sense of control and really be able to advocate is when we looked at the actual data. And so getting to that data seems to be difficult sometimes. But I think, I think it should be a big part of the communication piece. Healthcare Leader 11 (HCL Focus Group 3)

Streamlining the process for already-qualified physicians and surgeons from other countries, who are here to become certified to be practicing medicine here. Patient 10 (PT Focus Group 2)

Bringing in other medical personnel from other provinces, other countries on temporary basis. Patient 7 (PT Focus Group 1)

There's a population of international physicians who often have a hard time getting resident spaces because they're competing with our medical students who are fresh out of medical school. Patient 5 (PT Focus Group 1)

SEND PATIENTS ELSEWHERE

Send patients out of province or country

Is there an opportunity in the short term to create some partnerships with some institutions in the US to manage some patient care? Maybe you have to give people the option for that, obviously you don't want to force anybody to go out of country for care, but maybe there's some options to expand capacity temporarily through these partnerships. The most obvious thing would be inter-provincial right but I'm assuming that's already been explored. Patient 2 (PT Focus Group 1)

Is there an opportunity in the short term to create some partnerships with some institutions in the US to manage some patient care? Maybe you have to give people the option for that, obviously you don't want to force anybody to go out of country for care, but maybe there's some options to expand capacity temporarily through these partnerships. The most obvious thing would be inter-provincial right but I'm assuming that's already been explored. Patient 2 (PT Focus Group 1)

The same way we flew in COVID patients, could you fly out hip and knee and patients who've been waiting to hospitals that have availability? Patient 8 (PT Focus Group 2)

With the surgery that I had, I think about 15 years ago, it was not readily available in [province] and they were flying patients to the US to have the operation done. And OHIP was covering it. So if you have to wait an outlandish amount of time in [province], why can't they

Now the priority is urgents and long waiters, but the reality of what happens at the hospital level is urgents are getting in and long waiters are not. And we dug into it to find out why by looking at the systems that they're using to allocate OR time – they're using lighthouse data [system that flags if patients are outside accepted surgical wait benchmarks]. If urgent is a day over benchmark, they immediately get put in, whereas a non-urgent – not elective but scheduled for 12 weeks – they could be three times their benchmark and they don't [get prioritized]…more waiting. So we've kind of realized that there's a big problem there and we're trying to advocate for the long waiters but it's [done] at the system level through the benchmarks Healthcare Leader 11 (HCL Focus Group 3)

When we're looking at data, really look at apples to apples comparison of data. There was a legislation change, where the surgeons now have to do the history and physical for the patients. So when you look at Wait 2's, most of those Wait 2's look very short, it almost doesn't seem like there's a concern, but we're not looking at all indicators and all pieces of the puzzle. So really having a comprehensive scorecard per hospital that takes into account the wait times but also other procedures. Healthcare Leader 16 (HCL Focus Group 4)

Provide surgeons with data on their wait times

I'm [in leadership] for wait times for benign general surgery, so non-cancer. We actually collect information on all the cases and know what the wait times are. We used to have dashboards that went out to individual surgeons about their activity. I think that has diminished since then. They were very effective because they told individual surgeons what was in their queue and what their wait times are. That information to individual surgeons, plus to the surgical leads, the surgeons-in-chiefs would be very valuable to help individual hospitals deal with their issues. Healthcare Leader 5 (HCL Focus Group 2)

Triage those on wait list to other services for management

Interventional radiology can offer some procedures that avoid surgery. I think in the chronic pain world that's also you know there are some procedures that interventional radiologists or anesthesiologists can offer, but often the connections aren't there so patients will be in a surgical waitlist but they can't access those other people. So if there was a more streamlined pathway and kind of guidelines about you know what you do first and what you can access that would certainly relieve surgical lists. [Healthcare Leader 11 (HCL Focus Group 3)

Restart wait list counting

Stop counting, start from scratch. I remember sitting in a radiology presentation, they were talking about the backlog of mammography, and they were showing a slide that said by 2035, we will have caught up to less than 10,000 mammograms and I thought to myself how incompletely clinically significant that was. Healthcare Leader 13 (HCL Focus Group 3)

send you to out of province or even out of country. Patient 10 (PT Focus Group 2) Could we do a big push, just to catch up, of out-of-province care for all the people who have waited for more than, let's say, 10 months for something that really affects your life. And you're going to be flown out to another province or another country to get the care so that we can catch up to pre-pandemic levels. Patient 8 (PT Focus Group 2)	I like the idea of starting from scratch. How do we know what these numbers mean? I'm not I'm not minimizing the problem at all, but I'm not sure that we can look at these numbers and react appropriately. To give you a bit more concrete example of that, you're all familiar with the P1 to P4 priority categorization for access, right? We can all distinguish between what's a P1 versus P4 on the oncology list, but we can sit in a room and I can argue for you that this is a P3 and you can argue with me that it's a P4. So there's a problem I have with these numbers. There's a massive conflict of interest as well, that we work in a fee for service model. If the only thing [surgeons] can access is P3's, then their cases are going to start becoming P3's, appropriately, because they're going to look after patients and they also need to be employed. Healthcare Leader 12 (HCL Focus Group 3)
IMPROVE AND EXPAND SERVICES <u>Improve efficiency and coordination</u> Is there a way for us to optimize surgeons' time? I don't know what exactly happens at the day of life of a surgeon, but so that surgeons time is used in surgery as opposed to in administrative tasks. So, optimizing their availability. And if we can minimize that so that we can maximize OR time, especially just during this period where we're so backlogged. Patient 10 (PT Focus Group 2) Schedule a surgery before scan comes back instead of waiting for the scans come back, you know that might save some time for sort of a placeholder appointment. Patient 7 (PT Focus Group 1)	<u>Centralized referral</u> One alternative would be each institution publish, by specialty, their waiting time for the benign surgeries, for cancer surgeries, etc. That helps practitioners to send patients to certain institutions and help with the backlog. So to have central information about that. It may help in sending patient to a centre that has less cases, less waiting time than the others. Not always is going to work because some of the patients are gonna need the high complexity hospital, but may help a little bit. Healthcare Leader 1 (HCL Focus Group 1) I'm not sure if there is an organization already to gather this information about waiting time. It would be interesting for any practitioner to go there and see these are the waiting times and we may change next month or periodically as we feed them. Healthcare Leader 1 (HCL Focus Group 1)
E<u>xtend services</u> All the areas like CT scans and MRIs have to be open 24 hours a day. They might be in some hospitals, but I was up at [hospital] at one point and I had to wait overnight because the CT didn't start until seven or eight in the morning. Patient 3 (PT Focus Group 1) There needs to be more resources, because I was supposed to have an MRI in two weeks. And now, because it's only available at that specific hospital and it's booked, they have to postpone it now to January. Patient 11 (PT Focus Group 2) There's a huge need in the eye care side of things, and they're reducing and reducing the number of services that are covered by OHIP. So could we reverse that trend? My mother-in-law got her cataracts done at a private clinic a few years ago and she didn't wait, she paid 800 bucks and boom, boom, done, no problem. So can we	One suggestion is to collect information about the waiting time for the most common surgeries performed by specialty through a time benchmark. As example, in general surgery, a benchmark for hernias would be 6 months, the number is matter to debate, just example. Hospital would report to a central organization how is their waiting time in regard the benchmark: below or above. Who would store this info? Possibly someone that would provide public and physician access. Therefore, the GP would know which hospitals would be in adequate benchmark for their patients and give preference to send those ones. Healthcare Leader 1 (HCL Focus Group 1) We need regional coordination, some sort of wait times strategy that would look at coordinating these things in a regional level Healthcare Leader 7 (HCL Focus Group 2) I know that there was a centralized list for cardiac surgery that worked well. What we do, for example, is to say, 'you can wait six months with Dr. X or you can have Dr. Y in a month. Your choice.' Healthcare Leader 18 (HCL Focus Group 5)

expand that to reduce the backlog in hospitals and put more people through? Patient 8 (PT Focus Group 2)	Having some digital mechanism to facilitate referral, and I think that's a great way to streamline, a single entry point for patients, making it really easy for patients and also emphasizing patient choice if they want to get the procedure done sooner, they will switch surgeons to the next available surgeon, or if they want to remain with their surgeon that they did the pre-surgical consult with, they have that choice. Healthcare Leader 8 (HCL Focus Group 2)
FUNDING <u>Fee for service</u> Pay per cut, if you will. The ones who are paid on salary, they'll do what they can within the time that they're there. Whereas the ones that are per surgery…incentivize them somehow to do more. Patient 8 (PT Focus Group 2)	Our centre is a larger regional center and then we've got four smaller hospitals in the community, and they don't have the wait times, they're getting all their patients done, they don't have a backlog. So senior leadership has floated the idea of a regional referral program for things like ortho. Healthcare Leader 13 (HCL Focus Group 3)
<u>Solicit private funding/donors</u> We need to be innovative by working with private sectors to improve clinical workflow, because the money is there. One organization got $25 million to build a new building. Patient 6 (PT Focus Group 1)	I actually have no concern at all about patient worry around autonomy and the single entry models. I can tell you from 17 years of experience of doing relatively major abdominal surgery with associated mortality that patients, in general, if it's done well and expectations are set appropriately right from the beginning, that most patients are okay with that. They don't want to be surprised and last minute find out that they don't know who's operating on them, but the solution to all of this is going to be team-based care and part of it is, how do you build the most like high performing teams right. Healthcare Leader 12 (HCL Focus Group 3)
LEARN FROM PAST PANDEMICS, OTHER COUNTRIES (to better manage future pandemics) Pandemic management, whether it's COVID or one in the future, they certainly need to reevaluate how they manage that. For some reason, they threw out anything they learned from SARS or H1N1, all those mini pandemics, and went with some new model that really didn't help anybody. Patient 1 (PT Focus Group 1)	I was just going to add for the primary care piece. You know, we started a motion A referral, with our all of our primary care physicians during the pandemic. And that allows for them to access the wait times and the first available surgeon. So that, across the system, would be very beneficial for the primary care physician to understand who has the shortest wait times. Healthcare Leader 15 (HCL Focus Group 4)
Learning about what other systems are doing will be really important. What other similar countries are doing. Patient 5 (PT Focus Group 1)	You've alluded to this idea of regional integration, moving cases out of the mothership, so to speak, and it's a really interesting exercise to get everyone to come to the table for the benefit of the patients. They still have their own senior management teams, their own boards, their own financial structures and so it has been a really difficult exercise to get people to really pull together and recognize that everyone can play a part. Healthcare Leader 9 (HCL Focus Group 2)
Different countries have faced similar problems or continue to face similar problems. Are we hooked in to these global initiatives, seeking out best practices? Patient 9 (PT Focus Group 2)	We're trying to look at a province-wide wait list system to look at if I can get my [procedure] done in [city] because it's a shorter waitlist. [Healthcare Leader 17 (HCL Focus Group 5)
MANAGE THE WAIT LIST <u>Use data to identify bottlenecks</u> They may want to track and find the bottlenecks, start to finish, in the process of getting a surgery. It also would determine times… this typically takes six weeks, this takes six months Patient 1 (PT Focus Group 1)	**INCREASE POOL OF HEALTHCARE PROFESSIONALS**

There's the 1% that uses 30% of healthcare services so they are highly complex patients like myself who need specialized care. It needs to be separated between what's causing the bottleneck and what's causing the backlog. Is it just lots of people who need elbow surgery or is there some specific areas of specialty surgery that's needed, whether it's cardiology, oncology and endo or otherwise? Separate those out from, you know, the regular person who tears a tendon, which can happen to anyone at any time. Patient 5 (PT Focus Group 1)] A lot of scientists are doing great work in analyzing health data, and looking at trends and patterns. At [hospital], they're even able to predict when the emergency room will be busy by the hour. So, how can they apply that kind of thinking and analysis to the ORs, based on if they increase the capacity, put more ORs, and then come back to the patients and say 'hey, there's a backlog but based on what we know today, we think we can fit you in around that week, or that month.' So you kind of have an idea, and as you get close to that date, they will update you on 'yeah we thought we would be that week but it's going to be delayed an extra two weeks' or whatever. Patient 8 (PT Focus Group 2) Predictive analytics. Leveraging that to model and manage the ORs and the access and expected wait times Patient 8 (PT Focus Group 2) <u>Re-assess how procedures are prioritized</u> Patients and families like ourselves get confused with the words unnecessary, elective, scheduled. A heart surgery may not be considered necessary but might be more urgent and may not be elective. Someone who might be active in sports might say I don't want to wait one year, I want surgery now so my daily living is improved and I can go back to sports. Similarly, somebody who is senior might say the same, but they may be prioritized differently. So defining unnecessary based on patient family perspective will be very important. Patient 6 (PT Focus Group 1) <u>Centralized referral</u> I like the single entry. It should be anonymous and based on either your health history with a certain hospital or your location, if you're far from a hospital, what's the closest, or where there's a specialist for your specific condition. But not playing like a dating game of choose	<u>Need more staff of all specialties/staffing prediction models</u> We often talk about OR nurses, they're critical for sure, but you can't do anything without recovery room, you can't do anything without day surgery nurses. You can do some things without increasing in-patient beds like your same day optimization of joints and gyne patients and things like that. You need more diagnostic imaging techs. It's not just one particular professional that you need. And I think there's a lack of understanding of that. Healthcare Leader 20 (HCL Focus Group 5) There doesn't seem to be good coordination of forecasting of health human resources, between the Ministry of Health and Long Term Care and the Ministry of Education. What I'm hearing is that people can't get into, for instance, the nursing programs when we have a real and present current danger nursing shortages. Healthcare Leader 20 (HCL Focus Group 5) There's no proactive methodology, about what the real number of staff you need. Because all of those staff that are hired have vacation, they have predictable average sick days per year, extended medical leave days, education days, annual competency days. Plus, your projected mat leaves, also projected retirement. Where's the larger overarching methodology in order to predict future needs. And the reason why that is so critical is because it takes so long for these personnel to be trained to complete the course, complete the lab work, complete the clinical placement, and then do their orientation and when they're brand new to the operating room, it's you know four months of orientation. So, in order to grow a new operating room nurse, it's basically a year, at least between sort of posting and getting them through all of those pieces. So there needs to be much more proactive methodology, and then permanent funding, in order to maintain services. Healthcare Leader 20 (HCL Focus Group 5) <u>Employ alternative roles / expand scope of practice</u> Whether it's physician assistants, whether it's nurse practitioners with the anesthesia training, RNs that can administer anesthesia with the supervision of anesthesia, and really looking at new models of care that don't rely on one particular health profession but a coordinated team to increase the throughput through the ORs. Healthcare Leader 8 (HCL Focus Group 2) One of the things we need to have is the courage right now, and this is going to require leadership at many levels, to start looking at alternate patterns of staffing ORs. In our operating rooms, we have a heavily unionized environment. The OR nurses are either RN or RPNs. I spent probably the first 10 years of my career in the United States working with scrub techs. So these were not necessarily nurses. Many of them were post-military people. Outstanding people in the operating rooms, very skilled at what they did. Not terribly versatile, they might be cardiovascular, they might be orthopedics, very specialty specific.

your own surgeon, because that could be risky as well and then you end up with the same thing, the popular ones, all the people choose them. Patient 8 (PT Focus Group 2) Usually in hospitals there's many different doctors within the department that does the same type of surgery. If we say that person has 20 people on the waitlist and you only have seven, is there any way that we divvy it up so that it can be a little bit more even to reduce the overall wait time? Patient 5 (PT Focus Group 1)	This would require taking on unions and so on and so forth but I think the circumstances require that we consider this really seriously. (Healthcare Leader 9 (HCL Focus Group 2) Scrub techs was what I was used to working with, and they're incredibly good. We did address this briefly, sort of mid-pandemic, and it's a land mine. I didn't realize it was going to be, I just thought it was a normal thing to discuss. It's unions and this and that. It has to come from top down because when we try to address it from within, all it did was create more conflict and low morale, and it actually took an unstable system and made it a little bit worse briefly, so we kind of abandoned it. Healthcare Leader 6 (HCL Focus Group 2) The biggest limitation, other than surgeons, is allied staff, nursing, PAR nurses, people to sterilize the equipment and all that stuff. If you don't have them, you can't increase your supply, but unfortunately it's not a short term solution. Healthcare Leader 11 (HCL Focus Group 3) In terms of increasing surgical supply, there is a shortage of anesthetists as well so perhaps looking at innovative staffing models and reinventing the operating room staffing model. Healthcare Leader 16 (HCL Focus Group 4) I agree with the reinventing operating room staffing models. We need to get really innovative about reintroducing a couple of things like anesthesia assistant roles. The province used to fund AA programs, whereby they pay for a third if you paid for two thirds. They stopped that years ago, so we have to quit looking at sole practitioners that take four years minimum to make, eight if you're talking about an anesthetist, right, even without a fellowship. So we need to start looking at augmented programs like NPs and AAs and potentially even technical assistance to do scrub roles. Healthcare Leader 14 (HCL Focus Group 4) I agree, we have to look beyond the traditional RN, RPN roles within the OR. Healthcare Leader 15 (HCL Focus Group 4) I think down-skilling is a charged word. I see it as rather skill matching to the appropriate level of care required. So, if you're going to recover ASA 1s and 2s, you don't need a critical care PACU nurse to do that. But you do for ASA 3s and 4s, so I think it's a valid fear people have like, if it required 4 years of education before, why all of a sudden are we going to take somebody out of high school and send them to three months of TA school and then that's good enough. I understand where the fear of quote unquote down-skilling is, but I think if we could look at it as everybody working to their full scope of practice and skill matching to the acuity of the patient, which has to do with some surgical streaming, then it's no longer down-skilling. If I'm having a minor procedure, I don't need a critical care PACU nurse, that is a waste of resource. But in big organizations and in big health systems, we tend to go to the highest watermark because we think it's the safest, we don't stream because that's just too

	much work and too much chaos. Even changing the vernacular would help people understand that we're not down-skilling. We're working everyone to full scope of practice, which is professionally fulfilling for them as well as safe for the patient. Healthcare Leader 14 (HCL Focus Group 4) That's the main message here. You can't want NPs on your wards, so your residents don't have to go up and write orders every 10 minutes, and then try to say that we're down-skilling somewhere else when we're matching. So like you can't suck and blow. I just want that in red in, that document. Healthcare Leader 14 (HCL Focus Group 4) <u>Provide on-the-job training programs</u> Traditionally, nurses interested in doing [further education] would take an unpaid leave from their work, they take a course at college or go to an OR training course, and then they come into the hospital and do a preceptorship, and it would take maybe nine months or more before they're fully approved and functional. So we've put an in-house training program where their tuition costs are covered, they don't take an income hit and it's expedited so they're ready to work in less than six months. Healthcare Leader 9 (HCL Focus Group 2) The big issue we facing I'm hearing anyways is the human resource issues. So, the in-house training of nursing staff, I know through the surgical innovation fund. There's a lot of desire now to use some of that money to train staff. So I think that has to be number one. Healthcare Leader 7 (HCL Focus Group 2) <u>Increase rate/volume of health professions training</u> We're going to need to train more nurses, we're going to have to gear up the schools that are training them. But that's not a quick and easy thing. Healthcare Leader 3 (HCL Focus Group 1) Human resources is the biggest issue for us right now that we're battling across all the hospitals. We've started to do innovative things with having courses between multiple hospitals. But I hear stories that we just do not have enough nursing spots in the universities. So, we need to look at that as well because the shortage was predicted and just exacerbated by the pandemic, but we're not going to get ourselves out of this for quite a long time. Healthcare Leader 15 (HCL Focus Group 4) Absolutely first and foremost we need more RN and RPN spots in colleges, and that should have started when the pandemic started, but instead we're still talking about it now when the pandemic is winding down. But it takes four years to make an RN, two and a half years to make an RPN. They need to integrate specialized coursework into base degree curriculum. Because if you need to go to an ICU or if you need to go to an OR you need another three months to eight months of training after an RN degree or RPN diploma to get that specialized training. So if even some of the elective coursework could be streamed in the colleges or universities, it would at least have them out at the end of their base program ready to work

	in a specialty area, and they could replace some of their electives without cutting down on their core nursing curriculum. Healthcare Leader 14 (HCL Focus Group 4) This year, there's so many nursing students that couldn't graduate from different schools. We took almost 800 nursing students at [hospital] and tried to give them a placement of some form. Just don't allow that, don't allow schools to not graduate students because they couldn't find placements. Make it work. If anybody came to any of the surgical directors, I'm sure we would have put our heads together to come up with a plan of how we could support these nurses to have a clinical experience that was meaningful and graduate. Because the less number of people that graduated last year has created an even bigger issue. So it's almost like yes we can work on all of these things operationally, but it is so important to pull the educational system into this as well. Because we'll never go ahead. Healthcare Leader 16 (HCL Focus Group 4) <u>Incentives/support to retain nurses</u> We're trying to support each other so that we don't see teams leaving. We've lost a lot of leaders in our building just from the workload and the stressors. We've seen leaders leaving for a different career path, working from home, having a little bit more flexibility. Healthcare Leader 17 (HCL Focus Group 5) And the human resource component of it, and our inability to acknowledge our leaders through compensation or even acknowledgement, is very difficult to keep people within the organization. I have never seen so many people leave. Our work force now is so junior, and the patients are so sick. We have to do our work differently. Healthcare Leader 19 (HCL Focus Group 5) How can we retain nurses? We've done stuff here that we never wanted to do before. If you look at the new research literature of leadership in crises, you need to increase your flexibility. We have no flexibility in healthcare because do more for less has always been one of our things: be efficient, pick up another unit, what's the big deal. And I think nurses are tired. Healthcare Leader 18 (HCL Focus Group 5) There needs to be some permanent funding. The difficulty, when you get temporary funding, is that is only annualized, you cannot as an operations director attract staff into temporary positions. Healthcare Leader 20 (HCL Focus Group 5) You need permanent funding. With contracts, people look for permanent positions and so you lose them. You get them trained and then we lose them. And any downtown hospital looks great on a resume. They can go anywhere from that point on, especially as a new OR nurse or as a new pre-op nurse. Healthcare Leader 17 (HCL Focus Group 5)

	They say money is not everything, well I think money is a big part of it. We need to value our people and pay more. I mean, we can pay basketball players $20 million. What is healthcare worth to people? Healthcare Leader 18 (HCL Focus Group 5) I have never seen so many complaints and people leaving because they're being yelled at all day by patients, families, what they didn't do right, that has to stop too. I know people are frustrated, you go to a store you get hit almost by people. There has to be an awareness, everybody chill out, we're starting fresh, the rules apply again, and you're not allowed to do these things. So I think the people are leaving because they can't take it anymore. Healthcare Leader 18 (HCL Focus Group 5) Working in a downtown hospital, there is a premium that should be paid. It doesn't matter where you work in [province], your hourly rate is the same. But commuting into [city] or living in [city], there's a price differential. And we can't attract people because they can get a community job, short commute, cheaper, it may be free parking, or a lot less than it is to come downtown. You're not going to be able to attract them anymore. Healthcare Leader 17 (HCL Focus Group 5) It's Bill 124. Even though we're not unionized, now we can't do anything, you can't even give them a meal voucher because of Bill 124. Bill 124 is going to kill it us. Healthcare Leader 17 (HCL Focus Group 5) [Bill 124] is a policy stating that if you are a provincial funded position, there's zero flexibility to provide any increase in pay other than a 1% increase. So you can’t pay people 5% or 10% above, it's illegal. You can't give them a meal voucher or parking pass, it would have to be out of donated funds. [Healthcare Leader 17 (HCL Focus Group 5) I think it'd be really interesting to understand all of the incentives that were provided to intensivists and other physicians who were working during the pandemic and what sort of incentives were provided to other leadership during this time. Healthcare Leader 20 (HCL Focus Group 5) I remember anesthesia being paid or anybody being paid to work in ICU. And then when my NP went to long term care, I don't think there was an incentive. And I even had to fight to pay her mileage. Healthcare Leader 18 (HCL Focus Group 5) We’re struggling with our resources, nursing in particular, but I feel like we're stymied in terms of incentivizing when we have a lot of new people coming. I think we need actually probably double what we need. We really need better incentives to hire people, and to retain them. Healthcare Leader 6 (HCL Focus Group 2)

	Is optimal to increase not just the human resources but the morale of the people who are there and the retention because that was the issue that preceded COVID, we were already pretty precarious in many hospitals on our human resources and morale for retention even before COVID and I think that's where it really broke down during COVID. Healthcare Leader 6 (HCL Focus Group 2) There's a competing phenomenon where nurses are looking for balance. They've said 'we've served for 18 months, I've got to find something that's a little bit easier, maybe closer to home, I can get out on time.' Nurses that have been here 10, 15 years have decided to leave the OR. It's too hard to work, the days are too long, they've done their tour of duty being redeployed. And 85% of the nursing workforce is still female, their families are in distress, and now they've got to figure out a new life balance. So we don't have enough staffed beds, and therefore we have closed beds. Or we can't staff the full complement on any given shift of beds, and that causes us to temporarily not fill those beds, which causes surgeries to be canceled. Even if they're not canceled, we do a lot of shuffling here, it puts the OR on hold and then the OR times out, because again, the OR nurses need to leave on time. Healthcare Leader 14 (HCL Focus Group 4) We're pretty stretched thin at this point. Any more stretching is going to break the nurses. And then the big piece about burnout, because no one's really talking about it and there's no real strategies coming out to address the burnout. We've taken procedural nurses and put them in ICU. We've taken nurses who were used to seeing well patients and put them in ICU with COVID patients and some of them do have very real PTSD. And some of those mental health pieces, there's no resources to manage them given the backlog with mental health as well. Healthcare Leader 16 (HCL Focus Group 4) We need a provincial strategy for PTSD in healthcare workers. It's showing itself right now in movement in our system and staffing. But that's just the surface, that's the reason people are leaving and moving and choosing different careers, retiring, trying to find a better quality of life at another hospital, even in similar jobs. But the underlying problem is burnout, and to some degree, that the gravity of burnout with the far end of that spectrum is PTSD and mental health issues and what will be healthcare staff for years to come, and I don't think it's shown itself yet. Healthcare Leader 14 (HCL Focus Group 4) When COVID hit and there was a need to expand ICUs, the only way to expand the ICUs was to take nurses with critical care training. And so they were pulled out of the recovery rooms of ORs and ORs had to close. And then what subsequently happened is a good number of nurses have left the profession. So what's happened in [hospital] is any nurse within three years of retirement has either retired or gone part time. And then there's others who were younger who have just left the profession. Healthcare Leader 3 (HCL Focus Group 1)

	One of the things we might look at is an incentive for nurses to come back. If in [province] they offered a bonus for nurses to come back into the profession, you know maybe people would be willing to come back. Healthcare Leader 3 (HCL Focus Group 1) <u>Expedite licensing foreign-trained clinicians</u> Try to get internationally graduated nurses, try to adapt them to the Canadian system with some timely consideration to eventually help the system. Healthcare Leader 1 (HCL Focus Group 1) There's an untapped resource in international medical graduates. Healthcare Leader 8 (HCL Focus Group 2) **IMPROVE AND EXPAND SERVICES** <u>Extend and expand services</u> We almost always operate on weekends because of how many patients we have in the hospital. Healthcare Leader 6 (HCL Focus Group 2) We're doing weekend surgery, so it's expanding from five days a week to six or seven days a week model. Healthcare Leader 17 (HCL Focus Group 5) We learned that the opportunity to increase flow was to actually have the operating rooms run seven days a week, but to get the seven days a week was a challenge. Healthcare Leader 7 (HCL Focus Group 2) We need regional coordination, some sort of wait times strategy that would look at coordinating these things in a regional level. Healthcare Leader 7 (HCL Focus Group 2) We're talking about surgery, but we should also take into consideration all the diagnostics and support services that go along with the surgical backlog which is imaging, the CT scans, the MRI, labs. And so if we really want to increase the surgical flow we also have to look at those support services that enable those procedures to get done. [Healthcare Leader 8 (HCL Focus Group 2) The wait times for all the diagnostics are backlogged as well. So we do need to look at that around you know their hours of operation, their staffing models, because, you know, we need to have the MRIs, the CTS to to get our patients diagnosed and back into surgery if required. Healthcare Leader 15 (HCL Focus Group 4) <u>Increase bed capacity</u>

	We have areas in the hospital that could be used that were patient care areas. So focus on being able to expand hospital beds because there are patients who just can't get home. Expanding that even temporarily until we get through the backlog so that we can get through the patient cases. Healthcare Leader 6 (HCL Focus Group 2) We need to make sure that there's capacity and we don't fill up with the emerg bed because medicine can never get their patients out. Healthcare Leader 18 (HCL Focus Group 5) Patients who need to go home, they go home, or they get charged every day. Because we spend half our day arguing with patients and their families about why they don't want to go home. Now I know it sounds a little out there, but that's where we're at right now. [Healthcare Leader 18 (HCL Focus Group 5) There needs to be some consequences for patients arrive late or no shows or we have NPO [instructions to have no food or liquids prior to procedures] violations from patients coming in. All of a sudden you have unused time that you can't fill on the day. Healthcare Leader 17 (HCL Focus Group 5) People don't know where to go, there's nowhere in the system to go to. So a navigator coordinates all this and it has decreased the ED admissions. But if every big diagnosis like CHF or renal had a navigator to work with the physicians and the patients and the community services, the system would function better. Healthcare Leader 18 (HCL Focus Group 5) I still don't understand the Ontario Health Teams. They're all doing wonderful things but nobody's doing anything for me and I'm the one who's providing all the resources. So I have to understand how the OHT can work for me. Or eliminate that and give me navigators, that would be even better. Healthcare Leader 18 (HCL Focus Group 5) <u>Find alternate sources for equipment/supplies</u> One of the things that concerns me about the push to just increase volumes is a huge supply chain issue that we are actually starting to experience now. There's a huge backlog of casting, materials, crutches, surgical gloves. So unless there's alternatives for sourcing strategies, we will probably not be able to operate. So the supply chain piece definitely needs to be addressed. It's very unsteady and very worrisome. Healthcare Leader 16 (HCL Focus Group 4) We are hearing about global supply chain disruption. And that's fine if you're talking about paper towels at Walmart, but it's not okay if you're talking about core supplies that affect every service surgical service like gauze, gloves, drapes. Already hearing about sutures and chest tubes. Every day, something new. Healthcare Leader 15 (HCL Focus Group 4) <u>Improve efficiency and coordination</u>

	If we're talking about efficiencies and throughput, looking at standard practice around surgical packs, limiting the instrumentation, limiting choice, but customizing it to the surgeon will help with throughput in the ORs. Healthcare Leader 8 (HCL Focus Group 2) Improve the efficiency in the OR. They [surgeons] spend almost as much time waiting for the OR to be turned over and ready for the next patient as doing the procedure. And that's a very inefficient use of resources. Healthcare Leader 2 (HCL Focus Group 1) The one perennial problem we have in our place is OR efficiency. It just drives you crazy when you look at long OR turnover times, when you look at the amount of time it takes to get ready to actually start doing surgery on a patient. The problem is you only have anesthesia, nursing and surgery who are all reporting to different hierarchies, they're paid through different pots of money, through different mechanisms, incentivized in very different ways, and it is really, really difficult to get everyone to pull together to focus on the issue of maximizing OR throughput. These are not new challenges, but, you know, how do we overcome this now in the interest of getting a huge backlog of patients taken care of. Healthcare Leader 9 (HCL Focus Group 2) The truth of the matter is, fundamentally, we do not have a health system. What we have is a publicly funded health insurance for most physician services, for hospital care and some drugs for some people. One of the things that we've tried to do is put out funding for innovation in models of care. The solutions were brilliant, but they were based in a single clinic or a single hospital. The challenge is scaling it up, getting it beyond the individual hospital or clinic. That's where we need to try and incent these changes. I don't think it's the whole answer but it would help move forward. Healthcare Leader 4 (HCL Focus Group 2) The right case with the right surgeon in the right location. Not all cases need to be the tertiary care centre and yet people are traveling. There should be better systems to establish what the needs and demands are in certain regions and what's available there and prevent all that traveling to tertiary care centers. [Healthcare Leader 11 (HCL Focus Group 3) We talked about the regionalization model in our hospital a while back, and it's thought to be a very good idea in theory, but in [province], this will have a significant impact on hospital budget because it would give the appearance of, perhaps correctly, that smaller hospitals are cherry picking the easier cases to do, while the tertiary care hospitals do the big expensive cases. And that can directly impact on hospital budgets. It's a very good idea and could be operationalized in a relatively short time, but there is an impact from a hospital perspective. Healthcare Leader 10 (HCL Focus Group 3) Monitor surgeon up-skilling, compliance with standards

	Up-training surgeons. For example hysterectomy has been a procedure that's basically routinely done laparoscopically now, that change happened in the last 10 years, 15 years, but there's still some surgeons that just didn't bother to train to do it and are still doing it abdominally requiring more resources, more postoperative time. That requires fairly more stringent oversight, and I don't know if in other specialties and surgeries that still happens, but there's probably still some holdouts that haven't really gone the MIS route. Healthcare Leader 11 (HCL Focus Group 3)] **FUNDING** <u>More funding for hospitals</u> Hospitals have been running on a 25th percentile year after year after year after year. So what is available to most departments these days is a fraction of what was available 25 years ago. This pandemic has just brought this to the rest of the public. They weren't affected previously now they are. The answer is to start looking at better funding for hospital facilities so that there is the ability to, first of all, hire more nursing staff, and there is also not enough operating time for surgeons in this province in any specialty. The government needs to start looking at how they are dividing their funding. Healthcare Leader 2 (HCL Focus Group 1) There is no cushion in the Canadian healthcare system, everything was running at 100% prior to COVID. The lesson in this is we've run the system on no slack for the last 50 years and getting worse year by year. That's what we will all have to decide in Canada, do we want to pay more taxes to have more slack in the system? Healthcare Leader 3 (HCL Focus Group 1) Provide funding for additional operating room time, either extended hours, weekends evenings, etc. That was talked about quite a bit a few months ago, and then seems to have died down significantly and I asked our CEO recently, and to his knowledge, there is at this point in time no additional funding coming for extra surgical time. Healthcare Leader 10 (HCL Focus Group 3) Government needs to strategically fund a package program tailored to individual organizations for surgical recovery and that might look different site to site. Healthcare Leader 14 (HCL Focus Group 4) We haven't formally been afforded a surgical recovery budget over and above global. My understanding is that there is no accountability agreement. Like, the ICU beds came and we would get a letter saying that the Ministry of Health was funding 14 more ICU beds. Well, hold on. There's pre op, there's post op, there's PACU, there's regional room that needs to block the patient, and, and, and there's beds, which now are filled with COVID patients and nurses redeployed. We have yet to receive that for surgical recovery. I'm running a $15 million deficit in the surgical program with no funding source. And yet everybody's talking about surgical recovery. Healthcare Leader 14 (HCL Focus Group 4)

	The other thing I'm deeply worried about is the money spent in COVID, I'm worried there's going to be a financial hangover, and they're actually going to start to carve considerable amounts of money back out of healthcare. I'm already hearing words like service planning in our organization, which is cuts. I'm really worried they're going to tell us to do surgical recovery but ask us to save $5 million out of the portfolio. Healthcare Leader 14 (HCL Focus Group 4) <u>Bundled care model</u> Bundled care works for certain procedures and specialties and it doesn't for others. So, pre-op, the procedure, post-op, which includes home care, and include primary care because I know primary care is not included in the current bundles. So that there is a price set for the entire journey of care and all the partners involved in that care. So the partners are jointly incented to get that patient with the best health outcomes, close to home. I thought the Ontario Health Team would work in that kind of lens. We have to look beyond surgery and surgical backlog in terms of the journey of care. The model of care for me is not just the surgical model of care, . It's the entire model of care. And we have to pay for that. Healthcare Leader 8 (HCL Focus Group 2) It's a mind blowing concept, idealistic, but this is where the current negotiations around physician reimbursement - I like the idea of alternate payment plans - but there's gotta be some sort of give around the idea to put all the money into the pot for this procedure or procedures and see how it plays out. So not the traditional bundled care programs that are in place today, it goes beyond that. I fully recognize the evaluation of bundled care is inconclusive, whether it's truly cost efficient or not, and whether it's actually best for the patient or not, but I'm just putting it way out there. Healthcare Leader 8 (HCL Focus Group 2) <u>Physician funding models</u> We have excellent people but they all work in their own silos, we are not integrated as a system. It becomes a turf war and a matter of losing business and revenue because we work fee per service. If we could take this step forward so that physicians work on an alternate payment plan and get rid of these petty concerns, maybe we can work towards really programmatic work rather than having our individual turfs Healthcare Leader 9 (HCL Focus Group 2) Surgeons to be able to bill for some of the diagnostic procedural work. For example, our surgeons can't do FIT tests. So the patients get diverted to endoscopy without a FIT. That's just an example of something that if you change the billing codes, that could allow for more preventative work to happen, or at least a way to catch a lot of these things when the patients come to the surgeon. Healthcare Leader 16 (HCL Focus Group 4)

	How do you eliminate this competition between different surgical services? There's couple of ways. You put everybody on a salary with expectation of call commitments, vacation, etc., just like a government employee. And the other one is that you have a scoring system for all non-elective, sorry, not urgent but scheduled surgeries. that factors in quality of life, mortality, and you basically score patients, and then based on that, they get access. If you really want to get to the truth in terms of what's urgent in terms of priority from, we talked about suffering, oncology versus non-oncology, maybe if you took that off the table then you'd have a system that would more appropriately represent patients needs. Because we're not gonna be able to look after everybody. And so there's gonna be some tough decisions to make and maybe our funding models don't help us with that. Healthcare Leader 11 (HCL Focus Group 3) Salaried. I believe in that for a whole number of reasons, being a female in surgery. So salaried for all surgeons would be great from my point of view, you can leave the female part out. Healthcare Leader 13 (HCL Focus Group 3)

Concerns with recommendations discussed

Themes	Patients/Family	Healthcare Leaders
RE Same-day discharge	[related theme: conflicting messaging] I was told by an anesthesiologist that I should be absolutely staying overnight because of a heart condition that I had before my procedure. The day of the procedure I was given information about having somebody come by to pick me up. I was told by a nurse as soon as I woke up that I was supposed to leave the hospital immediately. When I told her this was problematic, and that it had been going directly against the orders the anesthesiologist, she came back to me and just said no, you're out, you're not staying overnight. Gave me no argument no explanation. It was just clearly trying to fit some sort of a rule or target. And she was trying to send me out of the hospital with nobody there to pick me up, or help me get home which was a very bad experience. It soured the good work of a lot of different people. Patient 7 (PT Focus Group 1) I think that a risk for same day discharges is a higher risk of returning to hospital. Right, because if you go out too early, you may not, if you don't have the proper support when you leave, you may have to go back. Patient 8 (PT Focus Group 2)	I think is a good strategy but I don't know how much they can increase without risking standard of care of the patient. Healthcare Leader 1 (HCL Focus Group 1) For somebody who is at a disadvantage or marginalized, a lot of these same day discharge, it is burdensome for them, and they just can't do it and I think that there needs to be some mechanism to provide health, education, physical help to accommodate individuals who actually can't get to facilities or can't manage their surgical procedures on the same day basis. Healthcare Leader 5 (HCL Focus Group 2) [related theme: conflicting messaging] I found has been really difficult culturally because if people do the same thing for a million years, I'll just give you an anecdote which was yesterday I did a surgery on an eighty-nine-year old, and I actually like to send them home the same day because I find that they get less confusion and so on. We did him under local anesthesia there's no reason he couldn't go home. I prepared the family for that they were ready to take him home. But when the pre admin area called them beforehand. The week before surgery just to go over their meds and everything. They told them Oh no, you'll stay overnight, because that's how culturally we always do it even though it's written all over the chart with it's the same day. So messaging is so important. I can tell the patients all I want and I can tell the other locations that interact with them, but unless culturally everyone is thinking about these things. They'll just fall back on keeping the patient because that's easier, honestly. (Healthcare Leader 6 (HCL Focus Group 2)
RE: Centralized referral model	I think one of the concerns people have is being forced to go to maybe a surgeon they're unfamiliar with or facility they're unfamiliar with. I think right now we generally have control over that. I think it would be worrying to people if they had to travel or be with somebody unfamiliar so equity issues and then also just patient comfort. Patient 2 (PT Focus Group 1)	I'm not sure if I would like to favor a patient to go to a surgeon that I've never seen. I know that there is a personal level in the matching and surgical treatment, so I'm not sure if the patient is going to like it. …One of my colleagues said something that I thought was very timely for this. He said, family physicians love single entry model unless it's with their own family. Healthcare Leader 1 (HCL Focus Group 1) Say you're talking about a single entry model, where patients wouldn't necessarily meet the surgeon they're going to be operated on until the day of surgery. I think a lot of surgeons would have a problem with that. Healthcare Leader 2 (HCL Focus Group 1) Yeah, a provincial single entry or a city single entry for certain I'm not sure if I would like if I were a patient to go to a surgeon that I've never seen I know that there is a personal level in the matching and surgical treatment, so I'm not sure if the patient is going to like it. Healthcare Leader 1 (HCL Focus Group 1)

Appendix 3, as supplied by the authors. Appendix to: Simpson AN, Gomez D, Baxter NN, et al. Patient, family and professional suggestions for surgical backlog recovery: a qualitative study. *CMAJ Open* 2023. doi:10.9778/cmajo.20220109.

		When you start to look at divvying up surgeries among a group of surgeons versus the one contact model you actually not only lose trust but increase medicolegal complications. Healthcare Leader 2 (HCL Focus Group 1) By doing that, you remove autonomy for patient decisions of where they want to have care with who they want to have care. And so I have a little bit of a concern about that as a concept. Yes, it makes sense to increase rapidity of procedure, but there's an ethical concern I'm not saying that it should or should not happen. just bringing it up for discussion sake. Healthcare Leader 10 (HCL Focus Group 3) I think the regionalization, you could...the surgeon is losing their autonomy with that, and it's a shift in their referral base, depending on what they're used to. Healthcare Leader 13 (HCL Focus Group 3) It also might negate access for certain more complex cases to, you know, the surgeons that have more experience. That goes along with the divvying up amongst surgeon single entry. I think, in all our specialties there's probably some level of cases that require that surgeon that has maybe more tertiary care experience with it and if it becomes a little bit more difficult to triage and make sure that the right patient gets to them and they're not blocked at the regional level because that surgery is named a surgery that should be done in the region. I think there's there's a danger of that. Healthcare Leader 11 (HCL Focus Group 3) The other one I would have is the [Nonprofit organization] idea. Again I completely agree with that from a medical perspective. My only concern is the question of who's going to be doing the adjudicating. It's one thing if physicians individually are asked 'please use [Non-profit organization], use your specialties criteria to make sortable decisions', totally on board with that. If you start having hospital committees and administrators of the government, talking about that to us, I would have a very serious concern because of losing more autonomy for physicians' work lives and I would have to juggle this point. Healthcare Leader 10 (HCL Focus Group 3)NOTE: org that helps reduce unnecessary tests, procedures etc.
<u>RE: Extended hours</u>	You also don't want burn out, you don't want the surgeons to burn out. So like further to her point like, you know, don't preoccupy his time with anything. You know, like extended work hours, like, you know, they shouldn't work more than like 12 hours. Like I heard like some surgeons that worked for like 36 hours straight. They don't sleep. Um, so that kind of affects the level of care they, they provide. Patient 11 (PT Focus Group 2)	We increased the days for operations in the past and now for Saturday as well. The problem is that nursing staff is extremely hard to find to provide the weekends. We try to hire and there is no one available. So, we are close to our limit on what we can offer such as weekend, and even thinking if it's gonna be a viable or continuous solution that you can provide in the next month. But we have a limit on how much we can increase because people are tired of overworking. And we have a limited number of staff as well. Healthcare Leader 1 (HCL Focus Group 1)

	Incentivising the quantity is concerning in that I would be worried about quality. I don't want my surgeon rushing through my knee replacement. Take your time. Patient 10 (PT Focus Group 2)	[HCP2] I would have to echo the nursing shortage. A lot of the nurses have been seconded to other areas in the hospital. And a lot of the ICUs across the province have been expanded into OR space or recovery room space. So we have kind of dual situation where there's not enough nurses to actually expand the hours, and there's not enough space to expand it into if you happen to be in an area where there is a higher incidence of COVID and more utilization of ICU time Healthcare Leader 2 (HCL Focus Group 1) When we ramped up last summer after the first wave subsided, we did elective surgery weekday evenings and on weekends, and the impact that it had across our perioperative program is that a number of OR nurses did not get summer vacation. And basically, you know, I think we contributed to the already you know suffering level of exhaustion and burnout that was going on. And we have a severe problem with, with just having enough perioperative staff to do what we need to do. Healthcare Leader 9 (HCL Focus Group 2) There was lots of talk about extra time and running late. We had a lot of kickback from our surgeons saying that everyone is very tired and burnout and the ability for the physicians to kind of make themselves available or have the energy to actually do this and do this safely people are concerned about that. And we're also, our hospital just launched an electronic medical record system in the middle of all of this, which had been planned before the pandemic started. So my past months, there's been no talk of kind of anything, that way we actually slow down to incorporate this and we're just trying to make sure the surgeons don't jump off the top of the building. So it's been, everyone's pretty tired is kind of the feeling I'm getting from my surgeons that if I said to them, like I can give you a 7 pm room because we would run 12 hour rooms, they would decline it because they didn't want it. Healthcare Leader 13 (HCL Focus Group 3) I mean I would say that's definitely an issue they come out with this plan to catch up and you know we hear they're going to run ORs at night and evenings and weekends and then everyone in the system goes, 'who's going to staff those ORs, we can barely staff for day ORs with nurses, we don't have enough nurses, we've had to close a bunch of ORs because the nurses, we have a crisis in our nursing situation. And then some hospitals did and it's by Health Authority and the same thing when they open the weekend ORs they had a hard time with the weekend ORs they had a hard time getting surgeons to come in on the weekend. [Healthcare Leader 11 (HCL Focus Group 3) Advocating for extended hours in the operating room when you can't even staff the ORs for existing nursing resources. It's just not going to happen. That's not a viable solution from a burnout perspective, from a wellness perspective or from an HHR perspective. Healthcare Leader 10 (HCL Focus Group 3)

		Interesting, I just was going to make one comment, so our wellness is obviously a major issue, has been for years, long before the pandemic. Our hospital does this wellness survey every quarter. In the one that came out maybe in January this year, they teased out the responses from physicians who work in periop so that would be surgeons and anesthesiologists, and it was really, really poor. And when we teased out the responses from those people, it turns out that they felt like they were dangling at the bottom of a chain with no information coming to them. Healthcare Leader 9 (HCL Focus Group 2)
RE: expediting licensing of foreign-trained clinicians	There's a reason that requirements there. I wouldn't be comfortable with knowing, for example, if a surgeon didn't have seven year training but instead they have five. That has to do with the education of the individual but also the quality of every provider in terms of safety and effectiveness. Patient 5 (PT Focus Group 1)	---
RE: More funding	You can say in the funding box I would say will that mean that other areas of health care have to be cut or will my taxes go up. And will other areas of healthcare be cut, because hospital funding goes up, because it's more like illness care right now than healthcare right. Like it's more on the reactive side than on the proactive side that we have our care. So, if we continue to feed the beast of hospital funding, then what does that mean for prevention programs. Patient 8 (PT Focus Group 2) How do we know whether the dollars are effectively affecting wait times, right. Like what's the marker of that. You know, along the lines of overall hospital budget and investing into like diagnostic imaging, as well as electronic referral processes, etc. are all amazing ways to do that, but we have like hospitals have tried that. And unfortunately, it still hasn't been successful. Well, why not? I think one of the reasons why it hasn't been successful is because there's politics involved, like you know where does the money go. I think people don't know we're spending about $40 billion dollars a year on health care. It's the biggest budget item that the [provincial] government has. And	**For hospitals** And I think that, you know, we're getting Innovation Funds or remote patient monitoring, all kinds of funding. But I don't think people are going to the root cause of the problem, and which we've alluded to before like the resource issues. Healthcare Leader 18 (HCL Focus Group 5) They can give us all the money but if you don't have the bodies to do the work, then it's not going to happen. Healthcare Leader 17 (HCL Focus Group 5) I think where we are right now is really defined by a nursing crisis. At this point in time like our hospital wants us to overperform the issue is not money. The issue is not that they won't open the ORs in the evenings and all that. We don't have the staff. And you know when you don't hear that up. You know even if you give hospitals money to hire staff, we're all competing for the same pool, there are not enough people in the pool. There is no quick and easy solution to this. You cannot pay your way out of this. Healthcare Leader 3 (HCL Focus Group 1) Increased funding doesn't solve the staffing problem for the next bucket. Like I think the whole province needs to be extraordinarily worried about the grave state, the crisis of healthcare staffing. That is the next pandemic that all of us will face. All the money in the world can't make a nurse overnight. I'm not hearing enough concern in the news or government. I really is crisis, staffing. I think most of us have horror stories to tell and it's mounting and it's getting worse not better. And so, it's a phenomenon related to the pandemic that that needs to be more on the minds of decision makers. Healthcare Leader 14 (HCL Focus Group 4)

	I think that it's better to look for efficiencies than just adding money. I know the local health units I attended some of their board meetings and all they wanted was more money, more money. And I think they didn't look at the fact that there's ways to be efficient. We have to put the effort into efficiencies, rather than just throwing money at it. Patient 1 (PT Focus Group 1)	If they're going to throw money at the problem, they need to let each institution decide what's the best way and how they can handle that. We've already come to the conclusion that extra hours don't work, so are there other ways to use the money to create efficiencies in the system and you know, kind of, let the people that are stakeholders come up with the solutions, not to come up a blanket solution for the whole system right. Healthcare Leader 11 (HCL Focus Group 3) **Alternative payment plan** I have lots of colleagues in [province] and I talked to them a lot about it and some of them are surgeons, some are not. But there is a caveat, once you relinquish your autonomy to governmental structure of salary, you also lose capacity to, for example, hire new people, get maternity leaves in, so they're working way harder. Healthcare Leader 11 (HCL Focus Group 3)
Reassess how procedures are prioritized	The Ministry of Health has a 15% premium on certain cases. Once you pass any 75% you then get a premium 15% more. So, there's an impression that these cases are being prioritized by the finance people in the organization. So these cases get dealt with first, everything else a second. And that's where you need to have a careful discussion of what are we really trying to do? Having the premium is really to ensure that these surgeries are done on weekends, on over time and so forth but I don't know if that's really being done. I think there's unintended consequences when you start to use these funding methods and applying things like premiums that has to be addressed. Healthcare Leader 7 (HCL Focus Group 2)	If we take the focus off of hips and knees, ortho will get their knickers in a knot, and the cataracts can be done outside of hospital, so I don't think that there's going to be a huge difference Healthcare Leader 2 (HCL Focus Group 1) For me I would also like to have the government relook at the Quality Based Procedures (QBP)s. And the reason is, is that, I think it's already been stated that they, you know, the non QBP cases are disincentivized, they don't get prioritized. And a lot of those clinical handbooks are old. They're not current and the, the link is really we get funded when we do the procedure, it's not related to outcomes or quality at all. The whole purpose of them was quality based procedures, and that's not how they're enacted. Healthcare Leader 20 (HCL Focus Group 5) Yeah, ethically, you know we don't have QBPs but you know we do have targeted funded procedures and we've made the decision to not do those procedures and hence were disincentivized because we're not getting the revenue coming in. Because we need to do cases that are top of the priority list, but you know it's hard at the Board table to say hey we lost all of this revenue because we had to prioritize these cases, and they're not funded, but they need to get done. QBPs were there way before the pandemic. And I think they either need to be paused, or you know just put on hold until we can get caught up but they're not necessarily the priority procedures. [Healthcare Leader 17 (HCL Focus Group 5) I guess if you're going to start doing less of those then, certainly, people would be concerned. If you're going to maintain them at the same level but increasing the others then I think people will be fine with it. Healthcare Leader 3 (HCL Focus Group 1) Just because hysterectomy is a quality based procedure, it does not mean that they are getting prioritized in any way shape or form, and the I think the number of

		hysterectomies in the province has gone way down with COVID Healthcare Leader 2 (HCL Focus Group 1) The quality based procedure really makes for two standards of care. So, I can tell you that my administration is really concerned that we do more hips and knees, as an example. And we actually [HCP2] we do pay attention to hysterectomy here. So we are trying to facilitate that. But my issue is, what about gallbladder, they're not a quality based procedure but does that mean that that person is not suffering with biliary colic, or what about hernias? So it's a very, very bad system when you prioritize one area above another. Healthcare Leader 3 (HCL Focus Group 1)
RE: optimizing efficiency and coordination	---	It's not about a system performance issue. I think we've been doing that for years. Like to say to wake up at the end COVID and say oh now we have to make this inefficient system work better. Hospitals on their own, because of annual budget cuts, have been working to improve the systems for a long, long time. Healthcare Leader 2 (HCL Focus Group 1)
RE: Shift services out of hospital	I would want to throw a caveat in there that I would be opposed to any moves to shift the business to private hospitals. I think it's always a danger. I personally really value our health system, the equity that's built into it. So anyway that would just be caveat, or concern that's a bit of a worry that I think is important. Patient 9 (PT Focus Group 2)	Out of hospital facilities, I worry about quality. Recidivism to ER, and surgical site infections or other complications, increased complication rate. Healthcare Leader 14 (HCL Focus Group 4) It's a huge culture shift for a lot of our surgeons, and there's a lot of resistance, just speaking for myself, in endorsing outside facilities. Because when the wheels fall off in those facilities, they're not open to care for those patients after hours and it's our docs who end up caring for the patients when there's untoward you know results. Healthcare Leader 20 (HCL Focus Group 5) It negates the whole Canadian health care plan. I know there's lots of private medicine going on in Canada and it's just as a principle you want people to have access-based not based on their financial situation right so. Healthcare Leader 11 (HCL Focus Group 3) **LEARN FROM PAST PANDEMICS** After SARS, I sat down just like we did now with people with the [organization] that the government asked with the same issues, 'what can we do, what can you learn from it.' And I think we learned a lot, but it all got forgotten after 17 years. Healthcare Leader 18 (HCL Focus Group 5)

